

Specialist nurses in gastroenterology

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A new species is emerging as a powerful force in the health-care environment. This phenomenon is particularly evident in gastroenterology, although the same changes are occurring in most specialties. Every aspect of gastroenterological care is seeing a rapid development and expansion of specialist nurses. They are taking their place alongside medical specialists, or establishing themselves as the principal carer. What advantages, if any, do they offer over the gastroenterologist? Are they a serious threat to consultant medical practice, or do they offer an important opportunity to improve patient care?

THE ECONOMIC AND POLITICAL MOTIVATION FOR CHANGE

This change in gastroenterological practice is occurring at a time of broad debate about changing roles for healthcare professionals. There is considerable political pressure for nurses to 'extend' their practice to encompass many functions formerly seen as the exclusive preserve of doctors. Indeed this change in nursing practice and responsibility is seen as one of the central means for effecting modernization of healthcare. A shift of power from doctors to nurses, by raising their status and increasing their responsibilities, is central to British government policy: '... nurses are at the centre of modernisation of the NHS—we have to liberate nurses—nursing skills and nursing values—so that you can be leaders of change'¹. Within defined constraints, the governing body for nursing endorses the trend to extending practice².

What motivates this reshaping of the hospital landscape? The provision of an effective healthcare system is rated highly by the voting public. Politicians worldwide are confronted by the conflicting demands of a health service increasingly hungry for cash to fund advancing technology, an ageing population requiring more care and a public that wishes to keep taxation low. Changes may also come from a real desire to move the focus of healthcare away from an insensitive technological approach to one based on holistic care.

At a time when the status of doctors is in decline, hastened by isolated but high profile 'scandals', it is easier to raise the status and responsibilities of nurses, whom the public regard with respect and affection. Other pressures have added to this process. These include a requirement to reduce the working hours of junior medical staff, and new training schemes which provide for more formal teaching and less face-to-face contact with patients. The medical focus is changing from treatment only, to active prevention strategies—for example, screening for colorectal cancer. Biological therapies, such as anti-TNF α antibodies for Crohn's disease, are substantially more expensive than traditional drug treatments. Consumers—that is, the healthcare-seeking public—are better informed and living longer. They are less tolerant of long waiting lists and want to be active participants in their own healthcare. Nurses are now generally better educated, within a university environment, and are more able to take on responsibility for patient care.

The reaction of doctors to change in the status of nurses has been mixed. Some have embraced change enthusiastically: 'Nurses can do some of what doctors do, usually to the greater satisfaction of patients'³. Others have been more guarded. But change seems inevitable. The question may be more about whether change will be imposed for the sake of political expediency or whether health professionals will take the lead in shaping the health service of the future.

WHAT IS A NURSE SPECIALIST?

There is a confusing proliferation of titles and roles, and a rapid expansion in the number and range, of nurse specialists working in gastroenterology. From the well-established stoma care nurse and those assisting in the endoscopy department have evolved nurse endoscopists, inflammatory bowel disease nurses, colorectal nurse practitioners, and a host of other roles in relation to irritable bowel syndrome, nutrition, behavioural treatments ('biofeedback'), and diagnostic tests such as manometry and ultrasound. The Royal College of Nursing stoma care forum has recently been relaunched as the gastroenterology and stoma forum, to reflect these changes.

The many different titles given to specialist nurses include clinical nurse specialist, nurse practitioner, advanced nursing practitioner and most recently nurse consultant. The last of these is a new breed of UK nurse designed to be of equivalent status and responsibility to medically qualified

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consultants. At present there is a lack of central regulation of titles and a lack of defining qualifications or training for most roles and titles, except for nurse practitioner. The UK Nursing and Midwifery Council (formerly the UK Central Council) is currently piloting a project to allow some nurses to register at a 'higher level of practice'⁴. A nurse should not be called 'specialist' only because she or he works in a specialist area; qualifications must be defined if high standards of care are to be met.

PROFESSIONAL BOUNDARIES AND THE NURSING PERSPECTIVE

Nurses can be taught to perform a range of tasks formerly considered within the medical domain. However, the assumption that this is the end goal of the current changes is to misunderstand a fundamental issue: nursing is complementary to, but different from, medicine. Nurses come from different backgrounds, have different professional goals, and are trained according to a different model. They have traditionally been less focused on professional status and financial gain. These attributes may be advantageous in terms of the changing healthcare environment. Some will argue that the traditional medical model used to train doctors, in which the main emphasis is on pharmacological or surgical solutions, is inappropriate to the needs of many patients. A large proportion of patients seen by gastroenterologists and other specialists have 'functional' disorders—conditions often associated with stress and depression. The inability of doctors to satisfy these patients is reflected in the popularity of 'alternative' therapies. Nurse specialists, placed somewhere between the two, may be well suited to meet patients' needs.

Patient care, irrespective of who provides it, must be holistic and individual. In the case of nurses, this has been summed up by Callum et al.⁵:

'We expect nurses to care with their hearts and minds; identify patients' actual and potential health problems; and develop research based strategies to prevent, ameliorate and comfort. We increasingly expect them to undertake work historically undertaken by doctors; we also expect them to be empathetic communicators who are highly educated, critical thinkers, and abreast of all the research findings'.

Nurses are unlikely to flourish in a setting in which their role is to perform a series of tasks that no-one else is available to do, or wants to do.

The current strategy for nursing⁶ proposes four levels of nurses, with progression based on competence and responsibility. It is designed to improve career progression for clinical nurses and keep expert nurses working with patients, rather than forcing them to move into management and

teaching. This retention of senior nurses in clinical practice is also part of the rationale behind development of the consultant nurse grade. Such consultant nurses must spend at least 50% of their time in direct patient care⁷.

THE POTENTIAL EXTENT OF NURSING PRACTICE

In UK law there are few legal limits to nursing practice, beyond such activities as certification of death and sectioning under the Mental Health Act which require medical registration. Most community nurses are currently trained, or soon will be, to prescribe from a limited formulary. Many nurses working in specialist areas supply medications according to agreed protocols. Nurse prescribing is likely to be extended to the acute sector in the near future, and may even include all trained nurses eventually.

The British Society of Gastroenterology (BSG) guidelines recommend that nurse endoscopy be limited to oesophago-gastro-duodenoscopy with biopsy, and flexible sigmoidoscopy with biopsy, in non-sedated patients, and with an experienced medical endoscopist available on site. The guidelines state that therapeutic endoscopy carries higher risks and should be done by a doctor⁸. However, in practice, nurse endoscopists are already performing colonoscopy and therapeutic endoscopy.

TRAINING

Defining the proper training for nurses in innovative roles is difficult for the pioneers. In the USA master's degree level preparation is expected for nurse specialists. Most nurses in the UK, even those working as specialists, do not even have a first degree, although a growing number are pursuing masters courses. There is also a small but growing number of validated courses within higher education establishments. In line with more rigorous medical specialty training, it is not acceptable for nurses to have undocumented ad hoc training on the job.

Many of the first nurse endoscopists received a more demanding and lengthy training in the procedure than existing doctor endoscopists⁹. The number of procedures required for competence, as judged by a trainer is, about the same¹⁰; therefore, guidelines recommend the same training for a nurse as for a doctor—150 procedures under supervision⁸. Increasingly, those trained as nurse endoscopists are in turn training other nurses, and junior doctors, to perform these procedures.

New roles cannot be sustained without the support of educational programmes, and education must be built into workforce planning¹¹. If doctors and nurses undertake at least some of their training together there is scope for better mutual understanding of similarities and differences in roles. Once in position, most nurse specialists and nurse consultants concentrate on clinical practice. More attention

will need to be paid to teaching, patient education, management, audit and research¹².

LEGAL AND ETHICAL ISSUES AND PROFESSIONAL RESPONSIBILITY

There is a feeling among some doctors that other professions 'want to chip in when the going is good, but as soon as there is a complaint they look to the doctor to carry the can'¹³. When new practices develop, where does accountability and professional responsibility lie? Nurses are individually accountable for their own practice. The Nursing and Midwifery Council says, 'You must acknowledge any limitations in your knowledge and competence and decline any duties and responsibilities unless able to perform them in a safe and skilled manner'². Nurses can be removed from their professional register for incompetent or negligent practice, in the same way as doctors, but new roles do not always have clearly defined expectations and boundaries. Where litigation does occur, the same test applies for negligence by nurses as applies to doctors—'what would be seen as reasonable by a group of competent peers' (Bolam test). For nurse pioneers, it is not clear whether other doctors or other nurses should be seen as the relevant peer group.

In the UK, within the National Health Service, the employing authority is responsible for financing and management of medical negligence claims. If nurses enter private practice they can, like doctors, make arrangements with a medical defence organization.

The British Society of Gastroenterology strongly recommends local written protocols and agreements for nurse endoscopists. Such documents would be a strong influence on what is regarded as 'good practice' for any new service or procedure, or in the event of cases of alleged professional misconduct. Other areas of specialist practice await such protocols.

ORGANIZATIONAL ISSUES

For patients and professionals to benefit from close cooperation between nurses and doctors, open dialogue is required¹⁴ to facilitate change and growth from within the existing service. There is much talk of 're-engineering' services by examining the patient's journey through a referral pathway and designing improvements at both administrative and clinical level. In this way, many hospitals have already cut to 2 weeks the wait to be seen for patients with suspected colorectal cancer. National targets, supported by political pressure and National Service Frameworks, do seem to have had a major impact in defined areas, by streamlining the process and developing a one-stop-shop approach, often led by a nurse specialist working within protocols. Nurses must 'own' these new specialist positions, which must be properly integrated to enable clear

lines of professional, managerial and clinical responsibility. In practice, many new posts are established with research or other temporary funding and are initiated by doctors. This can lead to later difficulties when the nursing budget is expected to pick up the cost of an established post.

CLINICAL EFFECTIVENESS

One of the major obstacles to use of nurse therapists is the lack of substantial research evidence and practice audit with which to measure the outcome of their interventions. Such data are urgently needed if resources are to be diverted in their direction. In this regard traditional medical practice is far advanced. However, there is increasing evidence that specially trained nurses can perform as safely and effectively as doctors in a range of conditions and procedures. Within nursing care there is also reason to suspect that patients who receive evidence-based nursing care have better outcomes than those who receive 'routine care'¹⁵. Many years will elapse before gastroenterological nursing has built an extensive evidence base. In some areas it is necessary to define how change might improve patient care, and to test these developments as they progress. Studies to date have compared nurses to doctors on technical competence, but have yet to consider qualitative issues, such as how the two professions do things differently, and how that might influence patients' experience of care as well as clinical outcomes.

Endoscopy

Nurse endoscopy has been extensively studied. Maule¹⁶ reported that, although doctors inserted a flexible sigmoidoscopy to a slightly greater depth than nurses, there was no difference in the pick-up rate of adenomas and carcinomas. Neither group had any complications. Significantly more (45% v. 30%) of the nurses' patients returned for repeat screening at one year. However, there was a possible selection bias in this study as symptomatic patients saw the doctor rather than the nurse¹⁷. Mashakis et al.⁹ found that an independent blinded assessor scored a specially trained nurse within 15% of her (doctor) trainer on various aspects of performance, with both achieving the aim of 60 cm insertion in over 70% of cases and reaching the descending colon in half, with no complications.

Randomized controlled trials¹⁸ have compared doctors with nurses performing flexible sigmoidoscopy as a screening test for colorectal cancer. Both have a miss rate of around 20% for polyps, as discovered on a repeat endoscopy. While doctors reach a greater depth of insertion, there is no difference in complication rates.

Nutrition nurse specialists

Nutrition nurse specialists work with all aspects of clinical nutrition but often focus on patients who need enteral

supplements or parenteral nutrition. The introduction of a nurse specialist has been found to reduce sepsis rates in parenteral intravenous feeding lines¹⁹.

Inflammatory bowel disease

The advent of nurse specialists devoted to inflammatory bowel disease (IBD) has been a very recent development. An increasing prevalence of inflammatory bowel disease, the chronic nature of the conditions, the need for surveillance related to cancer risk, the benefits of fine-tuning of drug therapy and encouraging drug compliance, and the increased familial risk, are all factors that weigh heavily on gastroenterological clinics. These aspects of IBD care are perceived to lend themselves to nurse management, in much the same way that diabetic nurse specialists have long fulfilled an important function in disease and complication management. Nurses are perceived to be more systematic, and to have more time to answer patients' queries.

Disease control and quality of life have been compared for the year before and the year after employment of an IBD specialist nurse in 339 patients in one centre²⁰. Hospital visits and the length of inpatient stays were reduced in the second year, and the number of patients in remission increased. Health locus of control and quality of life did not change significantly. There was a modest increase in patients' satisfaction about prescribed drug information and other aspects related to emotional support. Further studies are required to determine whether these effects were directly attributable to the specialist nurse.

Patients with IBD can be taught to self-medicate when they have a flare-up and to telephone for an urgent appointment if symptoms are not controlled within 5 days. In a controlled study this reduced clinic visits by 30%, decreased the delay between symptom onset and treatment from 4 days to under 24 hours, increased quality of life scores, and decreased costs. Virtually all patients preferred the new system²¹. Some physicians would argue that patients with IBD should still have at least an annual formal outpatient visit, for review of drug treatment, cancer surveillance, and other issues of concern. For unselected IBD patients provision of educational reading material alone does not alter quality of life²², but a nurse-supported educational package can increase adherence to prescribed treatment²³.

Colorectal nurse specialists

Colorectal nurse specialists already undertake a broad range of diagnostic, management, and therapeutic activities. These include rectal-bleeding clinics with direct access from primary care, management of common anorectal disorders, and ileoanal pouch care. In our own unit, nurses have assumed several roles in which they take responsibility for patient care from entry to the hospital system until

discharge. For example, in the treatment of functional large-bowel and pelvic-floor disorders such as constipation and faecal incontinence, nurse specialists are responsible for patient assessment and administration of behavioural treatments. If medical assessment or treatment is required—for example to exclude disease or to provide additional psychological treatment—the help of medical members of the 'team' can be invoked.

Management of chronic disease

Many gastroenterological conditions and diseases are chronic or recurrent in nature. These chronic conditions, such as inflammatory bowel disease and irritable bowel syndrome, consume a large part of the healthcare budget. The Government has proposed the concept of the 'expert patient' to address this issue. The emphasis is changed to teaching self-management, rather than the traditional paternalistic hospital-based 'illness service'. The hospital becomes only a part of the patient's healthcare, with an interactive relationship between nurse and patient tailored to the individual's ability and willingness to take responsibility for his or her own healthcare²⁴.

By assessing individuals' coping strategies it should be possible to decrease routine unnecessary outpatient follow-up. In the study cited previously, appointment of an IBD nurse specialist decreased clinic visits by 38%²⁰. Doctors might tailor outpatient management in the same way; a comparison with nurse specialists is needed.

COST-EFFECTIVENESS

There is a common assumption underlying the current changes that nurses cost less than doctors, and that if they do the same things the service should cost less. A simple shift from employing doctors to employing nurses is, however, unlikely to achieve the cost reduction or changes in healthcare emphasis that politicians and planners seek. While scope exists for restructuring²⁵, specialist nurses should not be regarded as cheaper or more readily available versions of doctors. Senior clinical nurse specialists earn a salary roughly equivalent to junior medical staff and the new nurse consultants will earn more. To our knowledge there have not yet been any comparative cost studies in gastroenterology. However, in a randomized controlled trial in general practice, nurse practitioners were found to cost the same per consultation as a general practitioner. Nurse consultations were longer and more tests were ordered. There was no significant difference in health status, prescribing or overall costs²⁶.

CONCLUSIONS

Nurses are often regarded as a lower part of the healthcare pyramid who can be substituted for doctors in a

straightforward way, with consequent cost savings. This is a misguided notion. It also neglects the special and different contribution that nurses make to patient care. Like doctors, nurses are a scarce commodity. Between 1984 and 1994 the number of nurses in training in the UK halved. During the same period there has been a huge increase in acute hospital activity²⁷. Creaming off the best nurses into new roles may impoverish the more traditional ward and outpatient nursing service, leaving only the more unadventurous and those unwilling to undergo further training to do what nurses have always done. There is also a danger of creating divisions among nurses, with those left behind to do the more mundane tasks resenting those who always seem to be going off to conferences and study days. Alternatively, development of new roles might be a way of making the career of nursing more attractive, by increasing career options and extending career pathways. This might secure more recruits to nursing.

The issue is not a simple reallocation of tasks between the professions. New ways of working together are required. There is a paternalistic assumption among some doctors that a skilled nurse aspires to become a doctor²⁸. An opportunity for nurses should not be regarded inevitably as a threat to doctors. In the UK state-funded healthcare system, income per patient is not an issue. In other countries, however, a fall in the number of procedures will mean less income for doctors²⁹.

The health service of the future will inevitably comprise an integrated workforce of multidisciplinary teams. It is important not to lose sight of the differences between doctors and nurses and focus only on their similarities: 'It is not what people have in common but their differences that make collaborative work more powerful than working separately'³⁰. Nursing is emerging as a scientific discipline that is distinct from, but complementary to, medicine⁸. There is a danger of losing the essential element of caring in a morass of technical procedures and pressures to reduce waiting lists. Enabling patients to cope with symptoms, often chronic, is as valid an endpoint in nursing as the successful completion of a technical procedure or achieving a 'cure'. Finally, quality of care, and addressing issues of importance to patients, should not be sacrificed in the quest to increase patient throughput.

The changes taking place represent an opportunity to improve the quality of healthcare in gastroenterology, particularly in the light of a new political commitment to invest in the NHS. The future of gastroenterological care will depend on making this collaboration work productively.

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